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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3593 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03568											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hancock Md.</b>						c. LENGTH OF STAY IN 1b <b>Life</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Murray Henry Allen</b>						4. DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 29. 1876</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>						11. BIRTHPLACE (State or foreign country) <b>Hancock Maryland</b>					
13. FATHER'S NAME <b>Monroe Allen</b>						14. MOTHER'S MAIDEN NAME <b>Katie Long</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>Elixabeth M Allen</b>					
17. INFORMANT <b>104 Fairview Drive</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Arterio Sclerotic Heart Disease</b> DUE TO (b) <b>Senility</b> DUE TO (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>recent</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>A. Su Dittig</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>J. E. W. Dittig</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>3.7.61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR <b>Howard F. Grose Hancock Md.</b>						24a. REC'D BY REGISTRAR <b>MAR 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haus</b>			

THE STATE  
ALABAMA



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DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
ALABAMA

Registration

Marriage License

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3594

## CERTIFICATE OF DEATH

03589

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>2200 Gay Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lavinia Elizabeth Barber</u>			<b>4. DATE OF DEATH</b> <u>March 18 1961</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan. 13 1902</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>4</u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hotel</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Frederick Md.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>			<b>13. FATHER'S NAME</b> <u>Charles E. Young</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Elsie Morgan</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>214 10 4291</u>			<b>17. INFORMANT</b> <u>Herschel H. Barber</u> <span style="float: right;">Address <u>2200 Gay St. Hagerstown Md.</u></span>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Generalized carcinomatosis of abdomen</u> (c) <u>Metastatic Carcinoma of uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Hypertensive cardiovascular disease.</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Minutes 6-12 months 4 years r</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2-9-49</u>, 19<u>  </u> to <u>death</u>, 19<u>  </u>, that (I) (we) last saw the deceased alive on <u>March 18, 1961</u>, and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert F. Keadle</u> M.D.			<b>22b. DATE SIGNED</b> <u>  </u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert F. Keadle</u>			<b>22d. ADDRESS</b> <u>318 North Potomac Street, Hagerstown</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 21-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lutheran Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Jefferson Md.</u>		<b>23e. (State)</b> <u>  </u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Alma Butler</u>			<b>24a. ADDRESS</b> <u>William B. Butler, Md.</u>				
<b>25a. REC'D BY REGISTRAR</b> <u>MAR 22 '61</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Huns</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



3501

CERTIFICATE OF DEATH

1901

Metastatic Carcinoma of the stomach  
Generalized carcinomatous of abdomen  
Ventricular dilatation

Myocardial degeneration in disease.

1901

1901

Robert E. Smith

312 North Potomac Street, Washington

Robert E. Smith



3595

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03590

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boonsboro</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>				d. STREET ADDRESS <u>166 SOUTH MAIN ST</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JOSEPH BURKETT BATMAN</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 22 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE -6-1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>9 16</u>		IF UNDER 24 HRS. Hours Min. <u>9 16</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>PAGE COUNTY VA. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY JACKSON BATMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA SHENK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>151-10-4799-F1</u>		17. INFORMANT Address <u>REV. RICHARD F. BATMAN Boonsboro MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> , 19 <u>61</u> , to <u>March 22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> , 19 <u>61</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Whelan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 24 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Whelan</u>				22d. ADDRESS <u>Boonsboro Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 25 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAUMS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PAGE Co. VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>Boonsboro MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>			

MEDICAL CERTIFICATION

2025



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**3596**

**03591**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>			c. LENGTH OF STAY IN 1b <b>41 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 W. Water St.</b>				d. STREET ADDRESS <b>11 W. Water St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>Myrtle</b> Last <b>Beard</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1867</b>		9. AGE (In years last birthday) <b>93</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chewsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry J. Poffenberger</b>				14. MOTHER'S MAIDEN NAME <b>Anna Rudisill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Anna Stem, Smithsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>10 Yrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/5</b> 19 <b>55</b> to <b>3/20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/19</b> 19 <b>61</b> , and that death occurred at <b>8:40 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles F. Hess</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>				22d. ADDRESS <b>Smithsburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 22 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

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CELESTINE ALETTA CAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Countersigned by E.W. Ditto 111 M.D. Med. Examiner

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>												2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>																																															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>												c. LENGTH OF STAY IN 1b <u>27 yrs.</u>																																															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>												d. STREET ADDRESS <u>1131 Hamilton Blvd.</u>																																															
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Elmer</u> Last <u>Brenner</u>												4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1961</u>																																															
5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>April 20, 1895</u>				9. AGE (In years last birthday) <u>65</u> yrs.				IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>				IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>																																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>												11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>												12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																							
13. FATHER'S NAME <u>John Brenner</u>												14. MOTHER'S MAIDEN NAME <u>Emma Ridenour</u>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW I</u>												16. SOCIAL SECURITY NO. <u>219-20-1895</u>												17. INFORMANT <u>Mary C. Young</u> Address <u>1131 Hamilton Blvd. Hagerstown, Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.0</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>45 MINUTES</u> <u>UNKNOWN</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>PULMONARY EMPHYSEMA</u>												20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>																																			
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>				Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>				20f. (City or town) <u>  </u>				(County) <u>  </u>				(State) <u>  </u>																																			
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 31</u> , 19 <u>61</u> , to <u>MARCH 31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MARCH 31</u> , 19 <u>61</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.																																																											
22a. SIGNATURE <u>E. R. Lardizabal</u>												22b. DATE SIGNED <u>APR 1, 1961</u>												22c. PHYSICIAN'S NAME (Type) <u>E. R. LARDIZABAL, MD</u>												22d. ADDRESS <u>St. Petersburg, Md</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>4/3/61</u>												23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>												23d. LOCATION (City, town or county) <u>Hagerstown, Md.</u>																							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>												ADDRESS <u>Hagerstown, Md.</u>												25a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>												25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>																							

Wm. C. Hov...





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03595

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>				c. LENGTH OF STAY IN 1b <u>12yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>121 1/2 Clarkson, Ave.</u>				d. STREET ADDRESS <u>121 Clarkson, Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Nettie Frances Brown</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 26 1949</u>	
9. AGE (In years last birthday) <u>12</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Lawerance Brown</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Stribling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Virginia Brown 405 Sumans Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>3 25.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mentally Retarded From Of 2 Years.</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Several Days.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>[Signature]</u> <u>3-13-61</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr. Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. RACE White		5. BIRTH DATE 1910		6. BIRTH PLACE St. Louis, Mo.	
7. OCCUPATION Teacher		8. MARITAL STATUS Married		9. PLACE OF DEATH Home	
10. DATE OF DEATH 1955		11. TIME OF DEATH 10:00 AM		12. CAUSE OF DEATH Heart Disease	
13. MANNER OF DEATH Natural		14. SIGNATURE OF EXAMINER [Signature]		15. SIGNATURE OF WITNESSES [Signatures]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEAREST RELATIVE [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]	
19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JURY [Signatures]		21. SIGNATURE OF JUDGE [Signature]	
22. SIGNATURE OF CLERK [Signature]		23. SIGNATURE OF NOTARY [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF DECEASED [Signature]	
28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]		33. SIGNATURE OF DECEASED [Signature]	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF DECEASED [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF DECEASED [Signature]	
40. SIGNATURE OF DECEASED [Signature]		41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF DECEASED [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF DECEASED [Signature]		45. SIGNATURE OF DECEASED [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF DECEASED [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF DECEASED [Signature]		51. SIGNATURE OF DECEASED [Signature]	
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55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF DECEASED [Signature]	
58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]		63. SIGNATURE OF DECEASED [Signature]	
64. SIGNATURE OF DECEASED [Signature]		65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF DECEASED [Signature]	
70. SIGNATURE OF DECEASED [Signature]		71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]		81. SIGNATURE OF DECEASED [Signature]	
82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF DECEASED [Signature]	
88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]		93. SIGNATURE OF DECEASED [Signature]	
94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF DECEASED [Signature]	
100. SIGNATURE OF DECEASED [Signature]		101. SIGNATURE OF DECEASED [Signature]		102. SIGNATURE OF DECEASED [Signature]	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3599

## CERTIFICATE OF DEATH

03594

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN lb <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 S. Artizan Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>106 S. Artizan Street</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Noland</u> <u>L.</u> <u>Brown</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>15</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 6, 1873</u>	
<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>9</u> Days <u>9</u>		<b>IF UNDER 24 HRS.</b> Hours <u>9</u> Min. <u>9</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Town of Williamsport</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Williamsport, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>David Brown</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Celia Butler</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>220 09 9257</u>		<b>17. INFORMANT</b> <u>Annie Brouddus</u> Address <u>106 S. Artizan St. Williamsport Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>DC. My ears did not function immediately</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/15/61</u> <b>to</b> <u>3/15/61</u> <b>19</b> , that (I) (we) last saw the deceased alive on <u>3/15/61</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Ralph F. Young</u> M.D.				<b>22b. DATE SIGNED</b> <u>3/15/61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Ralph F. Young</u>				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/19/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Riverview Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Williamsport, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Albert L. Leaf</u>				<b>ADDRESS</b> <u>Williamsport, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>DATE MAR 21 '61</u> <u>Arthur S. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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CONTINUITY OF DEATH

1922

Washington

St. Paul

St. Paul

Washington

St. Paul

St. Paul

100 S. Western Street

100 S. Western Street

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

3600

03595

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>60 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. STREET ADDRESS <b>13 Wynnwood Drive</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Franklin Carbaugh</b>				4. DATE OF DEATH Month Day Year <b>March 6 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1889</b>	9. AGE (In years lost birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Broadfording, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Carbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Ida Bloyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Maude I. Carbaugh Hagerstown, md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 442X DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Hypertensive cardiovascular disease</b> (c) <b>30 yrs(?)</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days -</b> <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-26, 1961</b> , to <b>3-6, 1961</b> , that (I) (we) last saw the deceased alive on <b>3-6 - 1961</b> , and that death occurred at <b>7:05 P</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John H. Hornbaker</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-7-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker</b>				22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				25a. REC'D BY REGISTRAR <b>MAR 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

CERTIFICATE OF DEATH

3800

Washington, D.C. \_\_\_\_\_  
Date of Death \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_

Occupation \_\_\_\_\_

Place of Birth \_\_\_\_\_

Usual Residence \_\_\_\_\_

Cause of Death \_\_\_\_\_

Immediate Cause \_\_\_\_\_

Underlying Cause \_\_\_\_\_

Contributing Cause \_\_\_\_\_

Duration of Illness \_\_\_\_\_

Time of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of Informant \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Medical Examiner \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3601

03596

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>			c. LENGTH OF STAY IN 1b <b>weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>W. Md. State Hospital</b>				d. STREET ADDRESS <b>358 Bedford St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy Virginia Carder</b> <i>Dorothy Virginia Carder</i>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1924</b>	
9. AGE (In years last birthday) <b>36</b> yrs.		10. UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>25</b> Min.		11. UNDER 24 HRS. Hours <b>25</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Richard Boyden</b>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Glen Carder, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> DUE TO (b) <b>pelvic metastasis</b> DUE TO (c) <b>carcinoma of cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pyelonephritis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 mos.</b> <b>18 mos.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19, 1960</b> to <b>March 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1961</b> , and that death occurred at <b>4:58 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Victor L. Ramon</b>				22b. DATE SIGNED <b>March 9, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Victor L. Ramon, M.D.</b>	
22d. ADDRESS <b>Western Md. State Hospital, Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-12-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

3501

CENTRIC OF DEATH

0378



East Coast, No.

1. 1st Hospital

2nd Hospital

3rd Hospital

4th Hospital

5th Hospital

6th Hospital

7th Hospital

8th Hospital



10

11th Hospital

12th Hospital

13th Hospital

14th Hospital

15th Hospital

16th Hospital

17th Hospital

18th Hospital

19th Hospital

20th Hospital

21st Hospital

22nd Hospital

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3602

## CERTIFICATE OF DEATH

03597

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Downsville</u> c. LENGTH OF STAY IN 1b <u>24 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Downsville Maryland</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Downsville</u> d. STREET ADDRESS <u>Downsville Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Stella May Dolly Cline</u> First Middle Last <b>4. DATE OF DEATH</b> <u>March 27 19 61</u> Month Day Year				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct. 10 1896</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <span style="float: right;">9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u></u> Min. <u></u></span>			
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>				<b>13. FATHER'S NAME</b> <u>Luke Wolford</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Ann Renner</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>none</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Mr. Harry Cline Sr. Downsville Md.</u> Address				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (e), stating the underlying cause last. <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>		<b>20f. (City or town)</b> <u>Downsville</u> (County) <u></u> (State) <u></u>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3/22/61</u> to <u>3/27/61</u> , that (I) (we) last saw the deceased alive on <u>3/22/61</u> , and that death occurred at <u>4 PM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Ralph Young M.D.</u>				<b>22b. DATE SIGNED</b> <u>3/27/61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Ralph Young M.D.</u>				<b>22d. ADDRESS</b> <u></u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 29-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenlawn Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Williamsport Md.</u> (State) <u></u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Albert L. Leaf Williamsport, Md</u> ADDRESS <u></u>				<b>25a. REC'D BY REGISTRAR</b> <u></u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>		<b>DATE</b> <u>MAR 30 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3002

CERTIFICATE OF DEATH

1950

121

1

*Handwritten signature*

*Handwritten notes and signatures*

may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3603

03598

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>329 Valley Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Gearhart Clugston</u>		4. DATE OF DEATH Month Day Year <u>March 1, 1961</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Clugston</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Gearhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>199-07-8279</u>	
17. INFORMANT <u>Chas A. Clugston</u>		18. ADDRESS <u>329 Valley Rd Hagerstown MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration of stomach contents</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebro-vascular accident</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Hemorrhagic cystitis ② chronic pyelonephritis</u>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 27, 1961</u> to <u>March 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1961</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos</u>		22b. DATE SIGNED <u>March 1, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. Ramos, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Mar 4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City, town, or county) (State) <u>near Greencastle Pa</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R E Munnich</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>			

MEDICAL CERTIFICATION

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some faint words and phrases are visible, including "CERTIFICATE OF DEATH" at the top center, "WILLIAM" on the left, and "JANUARY" on the right. The text appears to be a form or a letter, with various lines and paragraphs separated by spaces and punctuation. The handwriting is cursive and somewhat slanted.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3604 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>				d. STREET ADDRESS <u>111 Bloom's Alley</u>			
3. NAME OF DECEASED (Type or print) <u>Solia Mae Colmes</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-1873</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wise (?)</u>				14. MOTHER'S MAIDEN NAME <u>Wise (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>9170</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Burns of Legs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cystic Disease of Liver</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Probable Burn from coal stove at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> o. m. <u>2 20</u> p. m. <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>House</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Dittus III</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/16/61</u>	
EXAMINER'S NAME (Type) <u>Edward W. Dittus III, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 21 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John R Watson Jr. Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
**300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. NAME OF DECEASED _____		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE _____		4. RACE _____	
5. DATE OF DEATH _____		6. TIME OF DEATH _____	
7. PLACE OF DEATH _____		8. OCCASION OF DEATH _____	
9. CAUSE OF DEATH _____		10. MANNER OF DEATH _____	
11. SIGNATURE OF EXAMINER _____		12. SIGNATURE OF WITNESS _____	
13. SIGNATURE OF DECEASED _____		14. SIGNATURE OF NEXT OF KIN _____	
15. SIGNATURE OF CLERK _____		16. SIGNATURE OF JURY _____	
17. SIGNATURE OF JURY _____		18. SIGNATURE OF JURY _____	
19. SIGNATURE OF JURY _____		20. SIGNATURE OF JURY _____	
21. SIGNATURE OF JURY _____		22. SIGNATURE OF JURY _____	
23. SIGNATURE OF JURY _____		24. SIGNATURE OF JURY _____	
25. SIGNATURE OF JURY _____		26. SIGNATURE OF JURY _____	
27. SIGNATURE OF JURY _____		28. SIGNATURE OF JURY _____	
29. SIGNATURE OF JURY _____		30. SIGNATURE OF JURY _____	
31. SIGNATURE OF JURY _____		32. SIGNATURE OF JURY _____	
33. SIGNATURE OF JURY _____		34. SIGNATURE OF JURY _____	
35. SIGNATURE OF JURY _____		36. SIGNATURE OF JURY _____	
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39. SIGNATURE OF JURY _____		40. SIGNATURE OF JURY _____	
41. SIGNATURE OF JURY _____		42. SIGNATURE OF JURY _____	
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49. SIGNATURE OF JURY _____		50. SIGNATURE OF JURY _____	
51. SIGNATURE OF JURY _____		52. SIGNATURE OF JURY _____	
53. SIGNATURE OF JURY _____		54. SIGNATURE OF JURY _____	
55. SIGNATURE OF JURY _____		56. SIGNATURE OF JURY _____	
57. SIGNATURE OF JURY _____		58. SIGNATURE OF JURY _____	
59. SIGNATURE OF JURY _____		60. SIGNATURE OF JURY _____	
61. SIGNATURE OF JURY _____		62. SIGNATURE OF JURY _____	
63. SIGNATURE OF JURY _____		64. SIGNATURE OF JURY _____	
65. SIGNATURE OF JURY _____		66. SIGNATURE OF JURY _____	
67. SIGNATURE OF JURY _____		68. SIGNATURE OF JURY _____	
69. SIGNATURE OF JURY _____		70. SIGNATURE OF JURY _____	
71. SIGNATURE OF JURY _____		72. SIGNATURE OF JURY _____	
73. SIGNATURE OF JURY _____		74. SIGNATURE OF JURY _____	
75. SIGNATURE OF JURY _____		76. SIGNATURE OF JURY _____	
77. SIGNATURE OF JURY _____		78. SIGNATURE OF JURY _____	
79. SIGNATURE OF JURY _____		80. SIGNATURE OF JURY _____	
81. SIGNATURE OF JURY _____		82. SIGNATURE OF JURY _____	
83. SIGNATURE OF JURY _____		84. SIGNATURE OF JURY _____	
85. SIGNATURE OF JURY _____		86. SIGNATURE OF JURY _____	
87. SIGNATURE OF JURY _____		88. SIGNATURE OF JURY _____	
89. SIGNATURE OF JURY _____		90. SIGNATURE OF JURY _____	
91. SIGNATURE OF JURY _____		92. SIGNATURE OF JURY _____	
93. SIGNATURE OF JURY _____		94. SIGNATURE OF JURY _____	
95. SIGNATURE OF JURY _____		96. SIGNATURE OF JURY _____	
97. SIGNATURE OF JURY _____		98. SIGNATURE OF JURY _____	
99. SIGNATURE OF JURY _____		100. SIGNATURE OF JURY _____	

14

1

1. NAME OF DECEASED  
 2. SEX  
 3. AGE  
 4. RACE  
 5. DATE OF DEATH  
 6. TIME OF DEATH  
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 8. OCCASION OF DEATH  
 9. CAUSE OF DEATH  
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 100. SIGNATURE OF JURY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3605

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03600

1. PLACE OF DEATH a. COUNTY <b>Washington Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Conv.Home</b>				d. STREET ADDRESS <b>Intervale Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Jacob</b> Last <b>Corwell</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1873</b>		9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co. Caledonia, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas J. Corwell</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Hagerstown, Wash. Co. Maryland</b> <b>Mrs. Aletta Partlow 980 Jefferson Blvd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Dis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Arterial Sclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15, 1961</b> to <b>Mar 20, 1961</b> that (I) (we) last saw the deceased alive on <b>Mar 20, 1961</b> and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>David R. Brewer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>				22d. ADDRESS <b>Clear Spring Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 24 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Samuel S. Evans</b>	

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STATE OF NEW YORK  
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3606

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03601

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Pearl</b> Last <b>Delosier</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James D. Bragunier</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-3372</b>	
17. INFORMANT <b>Iran B. Delosier</b>		Address <b>726 W. Washington St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis of colon</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of colon</b> DUE TO (c) <b>met Hxm</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1961</b> to <b>Mar 19</b> 1961, that (I) (we) last saw the deceased alive on <b>17 Mar 1961</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edw D Gooden</b>		22b. DATE SIGNED <b>3/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E D Gooden</b>		22d. ADDRESS <b>Hagerstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>MAR 24 '61</b>	
ADDRESS <b>Hagerstown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL RECORDS  
BALTIMORE, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3607 CERTIFICATE OF DEATH 03602											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				d. STREET ADDRESS <u>24 High St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William Oscar Derr</u>			4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 61</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 16, 1916</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Oscar Derr</u>						14. MOTHER'S MAIDEN NAME <u>Belva Gay Palmer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW 2 (2)</u>				16. SOCIAL SECURITY NO. <u>214-09-7258</u>		17. INFORMANT <u>Mr. C.O. Derr</u>				Address <u>24 High St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ingestion of Prestone = Accidental</u> <u>888.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Alcoholism</u> cause last. (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs +</u> <u>2 days +</u>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally drank 1 pt. to 1 1/2 pt. of Prestone thinking it contained alcohol</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5:33</u> <u>3</u> <u>9</u> <u>61</u> p.m. <u>  </u> <u>  </u> <u>  </u> <u>1961</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Washington Md</u>				
21. I certify that (I) (this hospital) attended the deceased from <u>3/9 1961</u> to <u>3/10 1961</u> , that (I) (we) last saw the deceased alive on <u>3/10 1961</u> , and that death occurred at <u>8:35 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank F. Shupp</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/11/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank F. Shupp</u>						22d. ADDRESS <u>109 1/2 N. Potomac St Hagerstown Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hork</u>						ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3608

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03603

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>		d. STREET ADDRESS <b>10 X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELIZABETH</b> Last <b>EBY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. Shields</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-38-0734</b>	
17. INFORMANT <b>Mrs. Frank Cummings</b>		18. ADDRESS <b>9011 Eton Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF BLADDER</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>17 MONTHS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>DEC 16</b> , 19 <b>60</b> , to <b>MARCH 5</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>MARCH 5</b> , 19 <b>61</b> , and that death occurred at <b>11:30</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Antonio V. Pallagrosi</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO V. PALLAGROSI</b>		22d. ADDRESS <b>1500 PENNSYLVANIA AVE HAGERSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sabillasville Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Sabillasville Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Crager</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 10 '61</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03604

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>9 Hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1032 So Colonial Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMER MARGARET ELGIN</b>				4. DATE OF DEATH Month Day Year <b>March 11 1961 19</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 16 1895</b>		9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (State or foreign country) <b>Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Wolfensberger</b>						14. MOTHER'S MAIDEN NAME <b>No Record</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>				17. INFORMANT Address <b>Cameron E. Elgin 1032 So Colonial Dr</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Hypertension</b>												INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>year</b> <b>3 wks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1 PM</b> <b>1961</b> to <b>11 PM</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>10 Mar</b> <b>1961</b> , and that death occurred at <b>3 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Eldon D H Cochran</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <b>11 Mar 1961</b>									
22c. PHYSICIAN'S NAME (Type) <b>Eldon D H Cochran</b>						22d. ADDRESS <b>Hagerstown Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/13/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town, or county) <b>Hagerstown Wash Co Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>						25a. REC'D BY REGISTRAR DATE <b>MAR 15 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>					

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3608

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may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03605

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEWIS W. FAULDERS</u>				4. DATE OF DEATH Month Day Year <u>MARCH - 10 - 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB - 5 - 1883</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>		11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SOLOMAN FAULDERS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA COX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ROGER FAULDERS BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Atherosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>duodenal ulcer - hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>March 10 1961</u> that (I) (we) last saw the deceased alive on <u>March 10 1961</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Harrison MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 13. 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03606

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Hospital		d. STREET ADDRESS 229 S. Sixth St. 75X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Annie Long Foster		4. DATE OF DEATH Month Day Year March 25, 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Knobsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Adam Long		14. MOTHER'S MAIDEN NAME Jane Glunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address 229 S. 6th. St. Chambersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/25/61 19 to 3/25/61 19, that (I) (we) last saw the deceased alive on 3/25/61 19 and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks		22b. DATE SIGNED 3/27/61	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 North Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Knobsville		23d. LOCATION (City, town, or county) (State) Knobsville, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert R. Barlow		ADDRESS Chambersburg, Pa.	
25a. REC'D BY REGISTRAR DATE MAR 29 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

# CERTIFICATE OF DEATH

1911

(M)

<p>1. Name of deceased                  John Doe</p>		<p>2. Sex                  Male</p>	
<p>3. Age                  45</p>		<p>4. Date of death                  Jan. 15, 1911</p>	
<p>5. Place of death                  New York City</p>		<p>6. Cause of death                  Heart disease</p>	
<p>7. Signature of physician                  J. Smith</p>		<p>8. Signature of registrar                  A. Jones</p>	

Carroll A. T. Smith

VR A15 (4)  
15M 9/60

1960

UNITED STATES OF AMERICA

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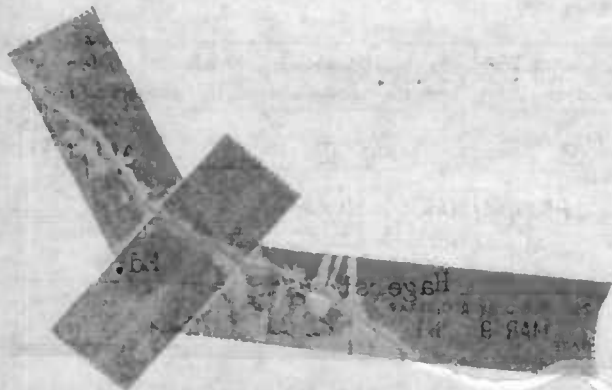
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03610

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. LENGTH OF STAY IN 1b <u>ONE YEAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYSVILLE MD. R.I.</u>				d. STREET ADDRESS <u>1 KEEDYSVILLE MD. R.I.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN STANLEY GREEN</u>				4. DATE OF DEATH Month Day Year <u>MARCH 17 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27 1922</u>	9. AGE (In years lost birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>		11. BIRTHPLACE (State or foreign country) <u>MT. AETNA WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAM GREEN</u>				14. MOTHER'S MAIDEN NAME <u>LULA SANDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-16-4029</u>			
17. INFORMANT <u>ADAM GREEN</u>				Address <u>KEEDYSVILLE MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Fever Heart</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2.5 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>January 10 1961</u> to <u>March 17 1961</u> , that (I) (we) last saw the deceased alive on <u>March 1 1961</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Wheeler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Wheeler</u>				22d. ADDRESS <u>Boonsboro, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 20 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1941

CERTIFICATE OF DEATH

1941



NAME: ADAM GREEN  
AGE: 25  
SEX: Male  
DATE OF BIRTH: 1916  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
DATE OF DEATH: 1941  
PLACE OF DEATH: [illegible]  
SIGNATURE: [illegible]  
WITNESSES: [illegible]

1941

ADAM GREEN  
1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3614

CERTIFICATE OF DEATH

Dr Harrison & Keadle

03608

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>22 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Unnamed baby of Earl Griffith</b>		4. DATE OF DEATH <b>March 27</b> 19 <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27 1961</b>
9. AGE (In years last birthday) <b>32</b>		10. IF UNDER 1 YEAR Months <b>32</b> Days <b>22</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Earl Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret J. Wynkoop</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Earl Griffith Sharpsburg R # 1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0 Congenital atelectasis</b> DUE TO (b) <b>Taylors Landing</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>22 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 26 1961</b> to <b>March 27 1961</b> , that (I) (we) last saw the deceased alive on <b>March 27 1961</b> , and that death occurred at <b>3:55</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul Harrison MD</b>		22b. DATE SIGNED <b>3/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr Paul Harrison</b>		22d. ADDRESS <b>318 No Potomac St Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew E. Coffman</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
ADDRESS <b>Hagerstown Md.</b>		DATE <b>MAR 29 '61</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please state the date the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3613 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03611

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN town <b>66 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>278 S. Prospect St.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>278 S. Prospect St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Frederick Griffith</b> First Middle Last				4. DATE OF DEATH <b>March 24 1961</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 17, 1894</b> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer self employed window</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John H. Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Burgur</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>220-09-9090</b>		17. INFORMANT <b>Mrs. Lula A. Griffith Washington D. C.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia - due to aspiration of vomitus.</b> DUE TO (b) <b>of vomitus.</b> DUE TO (c) <b>of vomitus.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary atherosclerosis - Severe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24-36 hrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <b>3/25/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 28 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

11/11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3616  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03609

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dargan</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ESSIE</b> Middle <b>LEE</b> Last <b>GRIMM</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dargan, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christopher Columbus Hanes</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Katherine Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Edwin Keller</b>		18. ADDRESS <b>RFD# 1, Harpers Ferry, West Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>Several years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Dr. H. B. Sizemore</b> attended the deceased from <b>July 1958</b> to <b>March 26, 1961</b> , that (I) <b>last</b> saw the deceased alive on <b>March 26, 1961</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. B. Sizemore</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. B. Sizemore</b>		22d. ADDRESS <b>Shepherdstown, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Samples Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Donald Eakles</b>		25a. REC'D BY REGISTRAR <b>APR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>		25c. DATE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3617

03612

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>	
c. LENGTH OF STAY in 1b <u>5 month</u>		d. STREET ADDRESS <u>216 Main Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine</u> <u>Ralston</u> <u>Guiney</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>21</u> <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19 1915</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Graduate Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Middlesboro Ka.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Zachary T. Ralston</u>	
14. MOTHER'S MAIDEN NAME <u>Katherine C. Vize</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220 34 0880</u>		17. INFORMANT <u>Mr. Joseph Guiney</u> <u>216 Main St. Sharpsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of ovary</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>175.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> <u>5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 9, 1960</u> to <u>March 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 21, 1961</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ed A. Hoffman</u> M.D.		22b. DATE SIGNED <u>3/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ed A. Hoffman</u>		22d. ADDRESS <u>214 N. Potomac St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-24-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williams</u>		25. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>	
ADDRESS <u>Williamsport, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Friend</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3618

03613

1. PLACE OF DEATH a. COUNTY <u>Wash. Co.</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3601-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>35 S. MONASTERY AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>George T</u> Middle <u>Hancock</u> Last <u>Hancock</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 18, 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIST DESIGNER FLAG, BANNER &amp; PENNANTS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>JOHN T. HANCOCK</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE L. POPE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>MR. ELMER G. HANCOCK 9149-11110 ST.</u>			
17. INFORMANT <u>RICHMOND HILL 18</u> Address <u>NEW YORK</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>1</u> Day <u>19</u> Year <u>1961</u> Hour <u>3</u> o. m. <u>2</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> 19 <u>61</u> , to <u>3-2</u> 19 <u>61</u> that (II) (we) last saw the deceased alive on <u>3-2</u> 19 <u>61</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>3-2-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>M E Byrkit</u>				22d. ADDRESS <u>Williamsport Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE, THEREOF <u>3/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADORIDGE MEM.</u>		23d. LOCATION (City, town, or county) (State) <u>DORSEY, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 8 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

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CENTRAL O. TRAIN

2118



*[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]*

CHIEF OF POLICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hancock Rest Home</b>		d. STREET ADDRESS <b>526 West "B"</b>	
3. NAME OF DECEASED (Type or print) <b>Ida Catherine Hanson</b>		4. DATE OF DEATH Month <b>3</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Manager Furniture Store.</b>		9. AGE (In years last birthday) <b>82</b> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward H. Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Ella V. Beck</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Florence Nicodemus, Brunswick, Md.</b>	
17. INFORMANT <b>Mrs. Florence Nicodemus, Brunswick, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>3 yrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 26, 1957</b> to <b>Mar. 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar. 17, 1961</b> , and that death occurred at <b>11:30 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>C.T. Byron Kao, M.D.</b>		22b. DATE SIGNED <b>Mar. 17, 1961</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Gum Spring Hollow Brunswick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-20-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FAIR VIEW</b>		23d. LOCATION (City, town or county) (State) <b>Farmers Ferry, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. G. G.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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EXHIBIT, 10/10/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>34 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>701 W. Washington Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>ROZELLA</b> <b>AGNES</b> <b>HARR</b>				4. DATE OF DEATH <b>March</b> <b>14</b> <b>19 61</b>				5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>July 4, 1899</b> 9. AGE (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Steelton, Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>											
13. FATHER'S NAME <b>Peter Francis Clark</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Murray</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-32-3862</b>											
17. INFORMANT <b>Mrs. Rozella A. Watson</b> Address <b>Philadelphia, Pa.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>444X</b> DUE TO <b>Myocardial Heart Disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis, General</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>10 yrs</b> <b>3 yrs</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 20, 1957</b> to <b>March 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1961</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above.																							
22a. SIGNATURE <b>Philip J. Hirshman</b>				M.D. <b>Philip J. Hirshman, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>3/14/61</b>											
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>				23a. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland</b>				23b. DATE THEREOF <b>3/16/1961</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Hagerstown, Maryland</b>				23d. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rogers</b>				ADDRESS <b>Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 17 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>											

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may be signed by the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3621

03616

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Naomi</b> Last <b>Harris</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.	11. IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Frederick, Md.</b>	
13. FATHER'S NAME <b>Richard P. Hagan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Keyser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Charles G. K. Harris, Boonsboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of aneurysm of ascending aorta</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>77 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 1960</b> to <b>March 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 30, 1961</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Heister</b>		22b. DATE SIGNED <b>3-31-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>Boonsboro Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4-1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William E. Thomas</b>			

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MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3622  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03617

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring</u>				c. LENGTH OF STAY IN 1b <u>30 Yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St</u>				d. STREET ADDRESS <u>1 Main St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>A</u> Last <u>HASSETT</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feby 5 1874</u>		9. AGE (In years lost birthday) yrs. <u>87</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Big Spring Wash Co Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hassett</u>				14. MOTHER'S MAIDEN NAME <u>Sara Edelen</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Elizabeth Ankeney</u>				Address <u>Big Spring Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>443 X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		21. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> 19 <u>59</u> to <u>March 13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>March 12</u> 19 <u>61</u> , and that death occurred at <u>11.30 AM</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Archie Robert Cohen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/14/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				22d. ADDRESS <u>Clear Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Little Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clear Spring Wash Co Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>				25c. REGISTRAR'S SIGNATURE <u>  </u>			

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CERTIFICATE OF DEATH

MADEY VILL AT DEPARTURE OF DEATH  
HAROLD J. BAYLOR, M.D.  
HAROLD J. BAYLOR, M.D.

CLARK BAYLOR, M.D.

CLARK BAYLOR, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3623

## CERTIFICATE OF DEATH

03618

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>D. O. A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>20 N. Artizan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Garfield</u> <u>Henry</u>			4. DATE OF DEATH Month Day Year <u>March</u> <u>30</u> <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15 1880</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days <u>6</u> <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Boss</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md. R. R.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Levi Henry</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Wisenburg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-9864</u>	17. INFORMANT Address <u>Mrs. Ada Henry 20 N. Artizan St. Md. Williamsport</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>Cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerosis &amp; Congestive failure 5 yrs</u> (a), stating the underlying cause last, (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20 1961</u> to <u>March 28, 1961</u> , that (we) last saw the deceased alive on <u>March 28, 1961</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.						
22a. SIGNATURE <u>M.E. Byrkit</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-30-61</u>		
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert A. Wolf</u>		ADDRESS <u>Williamsport, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 3 '61</u>		
				25b. REGISTRAR'S SIGNATURE <u>Clinton S. Kline</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3624

## CERTIFICATE OF DEATH

03619

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Mos.</u>		X c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring R # 1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>				d. STREET ADDRESS <u>*-----</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Henry</u> Last <u>Hesson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>61</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milk Processing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Peter Hesson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Mercer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-3182A</u>		17. INFORMANT <u>Paul R. Hesson 351 Elizabeth Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleed. Myocardial and Rt. Infarct Area</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 14, 1961</u> to <u>March 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 14, 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				22d. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> <u>Wm. C. Horst</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1200



John Carter



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3625  
CERTIFICATE OF DEATH

03620

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rt. #4</b>		c. LENGTH OF STAY IN 1b <b>37 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cearfoss Wash. Co. Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>WESLEY</b> Last <b>HOLLINGER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 29 1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>31</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bester-Long</b>	
11. BIRTHPLACE (State or foreign country) <b>Cearfoss Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Hollinger</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Welch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>312-14-6369</b>	
17. INFORMANT <b>Harry D. Spiekler</b>		Address <b>Greencastle Pa</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Occlusion in</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Obstructive Heart Disease</b> (c) <b>R # 2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 9 1957</b> to <b>March 31 1961</b> , that (I) (we) lost saw the deceased alive on <b>3/27 1961</b> , and that death occurred at <b>12:57</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE SIGNED <b>4/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Cearfoss Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>APR 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Pinner</b>	

CERTIFICATE OF DEATH

3030

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CHIEF OF BUREAU

W. D. M.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3626

03621

1. PLACE OF DEATH a. COUNTY <i>Mt. Vernon</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>Franklin</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Boonsboro</i>				c. LENGTH OF STAY IN 1b <i>6 Years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lakewood, Kiefer Memorial Home for aged</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waynesboro</i>				f. STREET ADDRESS <i>361 W. 2nd. St.</i>			
3. NAME OF DECEASED (Type or print) First <i>OLIVE</i> Middle <i>SNADER</i> Last <i>HORST</i>				4. DATE OF DEATH Month <i>3</i> Day <i>26</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/28/1895</i>	
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months <i>86</i> Days <i>86</i> Hours <i>86</i> Min.		11. IF UNDER 24 HRS. Months <i>86</i> Days <i>86</i> Hours <i>86</i> Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Duties</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Near New Windsor Pa.</i>			
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Evan Thomas Snader</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Eelen Baile</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>173-03-0956A.</i>			
17. INFORMANT <i>Mrs. Ida M. Baker, Waynesboro, Pa.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>450.0</i> DUE TO <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <i>February 10, 1961</i> to <i>March 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 26, 1961</i> , and that death occurred at <i>2:33 PM</i> , from the causes and on the date stated above. 22a. SIGNATURE <i>G. W. Helan</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>3/29/61</i> 22c. PHYSICIAN'S NAME (Type) <i>G. W. Helan</i> 22d. ADDRESS <i>Boonsboro Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/29/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Waynesboro, Franklin Co., Pa.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Grove, Waynesboro Pa.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 3 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

3028

Name of Deceased		Sex		Age		Date of Birth	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Date of Death		Time of Death	
Physician		Hospital		Burial Place		Burial Date	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Witness	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 3627 CERTIFICATE OF DEATH

03622

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 1011-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>				d. STREET ADDRESS <u>500 W. South Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>V.</u> Last <u>Hurd</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27- 1885 ?</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick-Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hoarse T. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Arianna Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-5246</u>		17. INFORMANT <u>Rosetta Duffins-22 Carver Apts. Fred. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>general arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>  <u>unknown</u>  <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Hypertension, benign ② cerebral hemorrhage</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>January 17, 1961</u> , to <u>March 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1961</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>March 20, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>		22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. HICKS 111</u>				25a. REC'D BY REGISTRAR <u>MAR 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Clifford S. Hanna</u>	

B/P

# CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3628

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03623

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tracys' Lane				d. STREET ADDRESS 728 Tracys' Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Solomon Earl Jacobs				4. DATE OF DEATH Month Day Year 3 10 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1891		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jacobs				14. MOTHER'S MAIDEN NAME Lucillia Mongan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-9301		17. INFORMANT Mrs. Irene Jacobs Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3-11-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-13-61		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. BURIAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3629

03624

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool Maryland</b>				c. LENGTH OF STAY IN 1b <b>2 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Micleta</b> Last <b>Keefer</b>				4. DATE OF DEATH Month <b>3</b> Day <b>6</b> Year <b>19 61</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2.14.1891</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>6</b> Hours <b>19</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Washington County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			
13. FATHER'S NAME <b>Grant Myers</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Shives</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Emmert L Keefer</b>				Address <b>Rural 2 Hancock Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Endocarditis</b> DUE TO <b>Arterial Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 15, 1960</b> to <b>Mar 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 5, 1961</b> , and that death occurred at <b>3:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>David R. Brewer</b>				22b. DATE SIGNED <b>3/8/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>				22d. ADDRESS <b>Clear Spring Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3.9.61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Methodist</b>				23d. LOCATION (City, town, or county) (State) <b>Rural Fulton County Penna.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Howe</b>				25a. REC'D BY REGISTRAR <b>Mar 10 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>							

CERTIFICATE OF DEATH

3639

Washington

Virginia

Washington

Local Health Officer

Physician

Physician

Death Certificate No.

Name

Age

Sex

Marital Status

70

Male

W

Residence

Occupation

Education

Married

Single

Place of Birth

Home

0

Signature of Local Health Officer

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

Signature of Physician

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03625**

**3630**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>141 Devonshire Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lester Mason Keller Sr.</b>				4. DATE OF DEATH Month Day Year <b>March 24 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1899</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Near Cearfoss, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Elmer Keller</b>				14. MOTHER'S MAIDEN NAME <b>Mary Toms</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-- --</b>		16. SOCIAL SECURITY NO. <b>-- --</b>		17. INFORMANT Address <b>Mrs. Wanda L. Keller Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic heart Disease</b> DUE TO (c) <b>Coronary Insufficiency</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/25/61</b>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fraw</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3080

M

<p>1. Name of deceased: <u>John A. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1880</u></p>	
<p>5. Place of birth: <u>Massachusetts</u></p>		<p>6. Date of death: <u>Jan 20, 1925</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of Medical Examiner: <u>[Signature]</u></p>		<p>10. Signature of Coroner: <u>[Signature]</u></p>	
<p>11. Date of certificate: <u>Jan 21, 1925</u></p>		<p>12. Office of Medical Examiner: <u>Boston</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
3631					CERTIFICATE OF DEATH					03626				
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR HAGERSTOWN</u>					c. LENGTH OF STAY IN 1b <u>10 YEARS</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FIRMWOOD CHURCH HOME</u>					d. STREET ADDRESS <u>805 FRIEDERICK ST.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>EULALIE</u> Last <u>LA MAR</u>					4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1961</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 10 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Hours <u>0</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>LEITERSBURG WASH. CO. MD. U.S.A.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>ROBERT LA MAR</u>					14. MOTHER'S MAIDEN NAME <u>NELLIE EAKLE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>NONE</u>					17. INFORMANT <u>MRS. ROSS BOWARD</u> Address <u>HAGERSTOWN MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure</u> DUE TO (c) <u>Myocardial enlargement</u>										INTERVAL BETWEEN ONSET AND DEATH <u>months</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 3/61</u> to <u>Mar 10 61</u> , that (I) (we) last saw the deceased alive on <u>3/61</u> , and that death occurred at <u>3A</u> M., from the causes and on the date stated above.														
22a. SIGNATURE <u>Louis G. Graff</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>5/10/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF</u>					22d. ADDRESS <u>119 E. Antietam St</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>MAR 12 1961</u>					23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>				
					23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. East</u>					ADDRESS <u>BOONSBORO MD</u>					25a. REC'D BY REGISTRAR <u>DATE MAR 15 '61</u>				
										25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				

15050

UNITED STATES OF AMERICA

15050

10/10/1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cavetown</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Box 5</b>							
3. NAME OF DECEASED (Type or print) First <b>Keifer</b> Middle <b>Edward</b> Last <b>Lewis</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1961</b>							
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1901</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>lumber comapny</b>		11. BIRTHPLACE (State or foreign country) <b>Wolfsville, Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Charles Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Etti I. Tracey</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-24-3013</b>		17. INFORMANT Address <b>Mrs. Eleanor Lewis, Cavetown, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> to <b>18 Mar</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>18 Mar</b> 19 <b>61</b> , and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>3/20/61</b>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cavetown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cavetown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>									
25a. REC'D BY REGISTRAR <b>APR 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

CERTIFICATE OF DEATH

3083

M

Deceased

11 days

11 days

Box 5

Washington County Hospital

Deceased

Deceased

Deceased

April 4, 1901

April 4, 1901

London County, Kentucky

London

Charles Lewis

212-24-3013, London, Kentucky

2-11-01, London, Kentucky

Robert I. Landon & Son, Indianapolis, Ind.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

3633  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 302 03628

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>418 Fremont St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES</u> <u>ELMER</u> <u>LONG</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>5</u> <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8 1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John C. Long</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. McNamee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-8034</u>			
17. INFORMANT <u>Mrs Ruth G. Cassidy</u>				Address <u>80 Devonshire Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic lung disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30</u> 19 <u>60</u> to <u>March 5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 5</u> 19 <u>61</u> , and that death occurred <u>11 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE <u>March 9, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. Beachley</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/7/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Salem Reformed Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>near Cearfoss Wash Co Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K Coffman</u>				ADDRESS <u>Hagerstown Md.</u>			
25a. REC'D BY REGISTRAR <u>[Signature]</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
DATE <u>MAR 10 '61</u>							

444



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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3634  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03629

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>13 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
f. STREET ADDRESS <u>439 Summit Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUE CATHERINE MACLAY</u>		4. DATE OF DEATH Month Day Year <u>March 3 1961 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 26 1873</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Prrstown Franklin Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clayton Stake</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>203-10-9491</u>	
17. INFORMANT <u>Mrs Bessie Munday</u>		Address <u>439 Summit Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>general arteriosclerosis +</u> (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>10-15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Diabetes Mellitus - osteoarthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1</u> 19 <u>61</u> , to <u>Mar 3</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 3</u> 19 <u>61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Dittus III</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Smithsburg Wash Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
ADDRESS <u>Hagerstown Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
ALBANY, N. Y.

2225

3635

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03630

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PEARL MARIE McCARRAHER</b>				4. DATE OF DEATH Month Day Year <b>March 14 1961 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 12 1892</b>		9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Berger</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Bragunier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Harry J. McCarragher Antietam Village</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b> <b>Carcinoma of head of Pancreas</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 12</b> 19 <b>58</b> to <b>Mar. 14</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Mar. 14</b> 19 <b>61</b> , and that death occurred at <b>A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Turco</b>				22b. DATE SIGNED <b>3-15-51</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. John D. Turco</b>	
22d. ADDRESS <b>302 N. Potomac Street-Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md</b>				25a. REC'D BY REGISTRAR <b>MAR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2032

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# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G204 4/7/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

03631

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>	c. LENGTH OF STAY in 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp.</u>		d. STREET ADDRESS <u>Breezewood, East Providence</u>	
3. NAME OF DECEASED (Type or print) <u>Lester</u> First <u>Eugene</u> Middle <u>Mellott</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Breezewood Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm H. Mellott</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Mellott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>obstructed both lower ureters</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of Prostate</u> DUE TO <u>6 mos.</u> lying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Artery sclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 26, 1961</u> to <u>March 28, 1961</u> , that I last saw the deceased alive on <u>March 28, 1961</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Crisp M.D.</u>		DATE SIGNED <u>April 3, 1961</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH C. CRISP M.D.</u>		<u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-31-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Luth. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Breezewood, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>James E. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15, 1925</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>Dec 10, 1970</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. NAME OF DECEASED <i>John Doe</i>		22. SEX <i>Male</i>		23. AGE <i>45</i>		24. DATE OF BIRTH <i>Jan 15, 1925</i>		25. PLACE OF BIRTH <i>Baltimore, Md.</i>		26. RACE <i>White</i>		27. OCCUPATION <i>Teacher</i>		28. MARITAL STATUS <i>Married</i>		29. DATE OF DEATH <i>Dec 10, 1970</i>		30. PLACE OF DEATH <i>Home</i>		31. CAUSE OF DEATH <i>Heart Disease</i>		32. MANNER OF DEATH <i>Natural</i>		33. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		34. SIGNATURE OF REGISTRAR <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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3637  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03632

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 1/2</u> Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRED JEROME MOORE</u>				4. DATE OF DEATH Month Day Year <u>March 9 1961 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 26 1871</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Potomac-Edison Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mt Vernon Knox Co</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William B. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Flaharty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>320-09-8909A</u>			
17. INFORMANT Address <u>Fla. Mr Don G. Moore Windermere Orange Co</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Cerebral Arteriosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>5 yrs.</u> DUE TO (c) <u>48 hrs.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>March 9 1961</u> that (I) (we) last saw the deceased alive on <u>March 8 1961</u> and that death occurred at <u>1955</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter N. Shear</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3/11/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER H. SHEAR M.D. Sharpsburg, Md.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mausoleum Rose Hill Cem Hagerstown Wash Co Md</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Cushing &amp; House</u>	

1934

CERTIFICATE OF DEATH

3093



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3638

03633

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>W. Md. State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WALTER</b> First <b>MOCK</b> Middle <b>R. MULLENIX</b> Last				4. DATE OF DEATH <b>MARCH</b> Month <b>30</b> Day <b>1961</b> Year			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1890</b>		9. AGE (In years lost birthday) <b>70</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>slsmn Bohman Warne</b>		11. BIRTHPLACE (State or foreign country) <b>Rileyville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles L Mullenix</b>				14. MOTHER'S MAIDEN NAME <b>Florence L Hoch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-9436</b>		17. INFORMANT Address <b>Mrs. Pearl Mullenix Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown</b>	(County) <b>Md.</b>	(State) <b>Md.</b>		
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>3-9-</b> <b>1961</b> to <b>3-30</b> <b>1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>3-30-</b> <b>1961</b> , and that death occurred at <b>3:45</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Antonio U. Pallagrosi M.D.</b>				22b. DATE SIGNED <b>APR 3 '61</b>		22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLAGROSI</b>	
22d. ADDRESS <b>1500 PENNSYLVANIA AVE HAGERSTOWN</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>4-1-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Hagerstown</b>	(State) <b>Md.</b>	23e. REGISTRAR'S SIGNATURE <b>Fred W. Kraiss</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Fred W. Kraiss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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CHILDS HOSPITAL

NEW YORK

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3639

## CERTIFICATE OF DEATH

03634

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1024 Main Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1024 Main Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Ray Emmert Munday</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 12 19 61</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>April 28, 1902</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fairchild Aircraft</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Hagerstown, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Norman S. Munday</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Moore</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>214-03-6316</u>		<b>17. INFORMANT</b> <u>Eston G. Munday</u>		Address <u>2006 Lexington Ave. Hagerstown</u> <u>Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>494X pulmonary embolism</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County)		(State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3/16/61</u> , 19 <u>61</u> , to <u>3/12/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/11/61</u> , 19 <u>61</u> , and that death occurred at <u>11</u> a.m., from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Dr. H. Weeks</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/13/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Howard N. Weeks, M.D.</u>				<b>22d. ADDRESS</b> <u>136 N. Potomac St., Hagerstown, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 14, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Hagerstown</u>		(State) <u>Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. G. Hook</u>		<b>ADDRESS</b> <u>Hagerstown, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 15 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03635

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greencastle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route #6, Hagerstown</u>		d. STREET ADDRESS <u>Route #1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harvey L. Niswander</u>		4. DATE OF DEATH Month Day Year <u>March 18 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1872</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Niswander</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Meyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Abram Shank</u>		Address <u>Rt. #1 Hagerstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive failure</u> DUE TO (b) <u>Seminal Arteriosclerosis</u> DUE TO (c) <u>lying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u> <u>2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/29 1959</u> to <u>March 18, 1961</u> , that (I) (we) lost the deceased alive on <u>March 17, 1961</u> and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>D. R. Hess</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>David R. Hess M.D.</u>		22d. ADDRESS <u>Shady Grove Pa</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>The Meyers Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>		25. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25a. ADDRESS <u>Greencastle, Pa</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>MAR 22 '61</u>			

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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3641

**CERTIFICATE OF DEATH**

Items 3 & 7 fill in 6203 3/27/61 iwk

03636

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>REEDER NURSING HOME</b>		d. STREET ADDRESS <b>136 EAST FIRST ST.</b>	
3. NAME OF DECEASED (Type or print) <b>BeverlyFirst Middle Last</b> <b>BEVERLY L. NORMAN</b>		4. DATE OF DEATH <b>MARCH 14 1961</b>	
5. SEX <b>MALIE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 19-1871</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BRICKLAYER AND STONE MASON</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HARRISON COUNTY W. VA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>C-RANVILLE NORMAN</b>		14. MOTHER'S MAIDEN NAME <b>LYDIA ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>235-12-4694</b>	
17. INFORMANT <b>MISS NAOMI NORMAN HAGERSTOWN MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with metastasis</b> DUE TO (b) <b>metastasis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>general arteriosclerosis &amp; arteriosclerotic heart disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 1 1953</b> to <b>Mar 14 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 12 1961</b> , and that death occurred <b>at 4 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b> M.D.		22b. DATE SIGNED <b>3/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>		22d. ADDRESS <b>217 West Washington St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAR. 16 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY CLARKSBURG W. VA.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b> ADDRESS <b>BOONSBORO MD.</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Kline</b> 25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. DITTO-III  
HAGERSTOWN MD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3642

CERTIFICATE OF DEATH

03637

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>14 Hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEANNETTE HENRIETTA RALSTON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 4 1906</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore city Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Cook</b>		14. MOTHER'S MAIDEN NAME <b>Anna Unkle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>315-22-8576</b>	
17. INFORMANT <b>John J. Ralston Hagerstown Md. R # 3</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma</b> DUE TO <b>Carcinoma Cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>171X</b> (c) <b>1 yr.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1961</b> to <b>Mar 3 1961</b> that (I) (we) lost saw the deceased alive on <b>Mar 3 1961</b> and that death occurred at <b>5:30 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>D. J. Boyer</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3-3-61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haged</b>	

CERTIFICATE OF DEATH

3025

11





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3643

03638

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home</u>		d. STREET ADDRESS <u>10x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>May</u> Last <u>Remsberg</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Remsberg</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Lighter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Md.</u> <u>Mrs. Noah Ed. Kefauver, Jr., Middletown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Cerebral vascular acid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis gen. yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hematoma of eye</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Explain nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> to <u>3/7</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>3/6</u> , 19 <u>61</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis G. Graff</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF M.D.</u>		22d. ADDRESS <u>119 E. Antietam</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/11/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

3823

1880



1880



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3644  
MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03639

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Md.</b>				c. LENGTH OF STAY IN 1b <b>80 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural 2 Hancock Maryland</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wesley</b> Last <b>Robinson</b>				4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>19 61</b>											
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4.7.1871</b>		9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>				11. BIRTHPLACE (State or foreign country) <b>Bedford County Pena.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Russell Robinson Rural 2 Hancock Md.</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio Sclerosis</b> (c) <b>10 da</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 da</b> INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> to <b>3/27</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> , 19 <b>61</b> , and that death occurred at <b>9:30 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>L M Shaffer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>3-29-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>L M SHAFFER MD</b>				22d. ADDRESS <b>HANCOCK, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3.30.61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stone Brethern Cemetery Rural Hancock Washington</b>				23d. LOCATION (City, town, or county) (State) <b>Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hansel J. Stone</b>				ADDRESS <b>Hancock Md</b>				25a. REC'D BY REGISTRAR DATE <b>PR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>					

CERTIFICATE OF BIRTH

Registration

Travel Hancock

1911

Travel Hancock

Home

1911

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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3645  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03640

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rur Hagerstown Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Md. Chronic Disease Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NELLIE A. ROBINSON</b>				4. DATE OF DEATH <b>MARCH 25 1961</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12.22.1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			
11. BIRTHPLACE (State or foreign country) <b>Washington County Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Issac A Younker</b>				14. MOTHER'S MAIDEN NAME <b>Mary C Hull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs FRank Eddy Rural 2 Hancock Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ABDOMINAL CARCINOMATOSIS</b> DUE TO (c) <b>CARCINOMA OF THE PANCREAS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>NOT KNOWN</b> <b>4 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-23-1961</b> to <b>3-25-1961</b> , that (I) (we) lost the deceased alive on <b>3-25-1961</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Antonio N. Pallagrosi</b> M.D.				22b. DATE SIGNED <b>3-25-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO N. PALLAGROSI</b>				22d. ADDRESS <b>1500 PENNSYLVANIA AVE HAGERSTOWN Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3.29.61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Brethern</b>				23d. LOCATION (City, town, or county) (State) <b>Rural Hancock Washington Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Houard J. Stone Hancock Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 29 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>				25c. REGISTRAR'S SIGNATURE			

0100

CERTIFICATE OF DEATH

2022

(M)

Washington

Alaska

Washington

The deceased was born on [illegible] [illegible] [illegible]

at [illegible] [illegible] [illegible]

and died on [illegible] [illegible] [illegible]

at [illegible] [illegible] [illegible]

causing [illegible] [illegible] [illegible]

which was [illegible] [illegible] [illegible]

and the cause of death was [illegible] [illegible] [illegible]

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 302 03641

1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 Week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				d. STREET ADDRESS <b>1133 Hamilton Blvd</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>EVELYN WASKINS RUBEN</b>				4. DATE OF DEATH Month Day Year <b>March 26 1961 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feby 8 1907</b>	
9. AGE (In years lost birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore City Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Kaulfman Waskins</b>				14. MOTHER'S MAIDEN NAME <b>Theresa Feinberg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Aaron Ruben</b>				Address <b>1133 Hamilton Blvd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>Carcinoma - Breast - Metastatic</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years.</b> <b>6 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 23 1960</b> to <b>March 26 61</b> , that (I) (we) last saw the deceased alive on <b>March 26 1961</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip J. Hirshman</b>				22b. DATE <b>3/27/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/28/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Abraham Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				25a. REC'D BY REGISTRAR <b>MAR 29 '61</b>			
ADDRESS <b>Hagerstown Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

CERTIFICATE OF DEATH

3008

(M)

(L)

CHIEF

CLERK

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

<div>Item 18 Filed 287 5-22-61</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>3647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03642</div>																												
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b> c. LENGTH OF STAY IN 1b <b>25yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1715 Fountain head rd.</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland.</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																						
<b>3. NAME OF DECEASED</b> (Type or print) <b>Jean Maire Kuss</b>			<b>4. DATE OF DEATH</b> Month <b>Mar</b> Day <b>13</b> Year <b>1961</b>			<b>5. SEX</b> <b>Female</b>			<b>6. COLOR OR RACE</b> <b>Colored</b>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>Oct 31 1934</b>			<b>9. AGE</b> (In years last birthday) <b>26</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																										
Months	Days	Hours	Min.																									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b> <b>13. FATHER'S NAME</b> <b>James Banks</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Private Family</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington, D.C.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>																						
<b>14. MOTHER'S MAIDEN NAME</b> <b>Beatrice Weathers</b>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>52-08-86996</b> <b>17. INFORMANT</b> <b>Mrs. Beatrice Tate 459 Park Place</b>																						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>057.1</b> <b>Aspiration of vomitus</b> DUE TO <b>Pulmonary congestion and edema</b> (b) <b>Cerebral congestion and edema</b> DUE TO <b>Wandering</b> <b>Meningococcemia?</b> (c)																												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)																												
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>																		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input checked="" type="checkbox"/>																												
<b>ACTUAL SIGNATURE</b> <b>Dr. E. W. Ditto, Jr.</b> <b>EXAMINER'S NAME</b> (Type)						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>3-14-61</b>																						
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>3-17-1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>22d. LOCATION</b> (City, town, or country) <b>Hagerstown Maryland</b>																				
<b>23. FUNERAL DIRECTOR</b> <b>John R Watson of Hagerstown, Md.</b>						<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>																				

MEDICAL CERTIFICATION

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Memo to Dr. D. 5/1/61  
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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

1968

11/1/68

1. Name of deceased: John F. Kennedy

2. Date of death: October 9, 1963

3. Place of death: Washington, D.C.

4. Cause of death: Assassination

5. Manner of death: Unnatural

6. Signature of physician: John F. Kennedy

7. Signature of medical examiner: John F. Kennedy

8. Signature of coroner: John F. Kennedy

9. Signature of registrar: John F. Kennedy

10. Signature of funeral director: John F. Kennedy

11. Signature of undertaker: John F. Kennedy

12. Signature of cemetery: John F. Kennedy

13. Signature of interment: John F. Kennedy

14. Signature of burial: John F. Kennedy

15. Signature of cremation: John F. Kennedy

16. Signature of other: John F. Kennedy

17. Signature of other: John F. Kennedy

18. Signature of other: John F. Kennedy

19. Signature of other: John F. Kennedy

20. Signature of other: John F. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3650

## CERTIFICATE OF DEATH

03645

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1114 W. Washington St.</b>				d. STREET ADDRESS <b>1114 W. Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Bell</b> Last <b>Schlotterbeck</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1870</b>	
9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Kneisley</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Cover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Mary I. Donat</b> Address <b>Hagerstown Wash. Co. MD. 119 West Side Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Cardiovascular Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <b>Arteriosclerosis</b> DUE TO lying cause lost, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1960</b> to <b>March 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip J. Hirshman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 30 '61</b> DATE	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

3020

95024

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15 1900*

5. Place of birth: *New York City*

6. Date of death: *Dec 10 1945*

7. Place of death: *New York City*

8. Cause of death: *Heart Disease*

9. Signature of physician: *John Doe*

10. Signature of registrar: *John Doe*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3651

03646

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield				c. LENGTH OF STAY IN 1b 3 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Highfield				d. STREET ADDRESS Ft. Meade 1601 Annapolis Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Liesbeth A. Sedlag				4. DATE OF DEATH Month Day Year March 28, 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/28/1908	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Breslau, Germany			
11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? Germany			
13. FATHER'S NAME Adolph Hirsch				14. MOTHER'S MAIDEN NAME Anna Kalinke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Mrs. Thadius A. Calimer, Highfield Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1961, to Mar 28, 1961, that (I) (we) last saw the deceased alive on Mar 28, 1961, and that death occurred at 11 PM, from the causes and on the date stated above.							
22a. SIGNATURE Robert A. Kiefer M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 29 May 61							
22c. PHYSICIAN'S NAME (Type) Robert A. Kiefer 22d. ADDRESS Blue Ridge Summit, Pa							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/31/61			
23c. NAME OF CEMETERY OR CREMATORY Bethel				23d. LOCATION (City, town, or county) (State) Lantz #1, Frederick Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Walter J. Grove, Waynesboro Pa.				25a. REC'D BY REGISTRAR APR 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			





may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03647

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash. Baltos.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>14 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>E LIZABETH ROESSNER SHANK</b>		4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1908</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>20</b> Days <b>0</b> Hours <b>0</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>Hagerstown, Md.</b>	
13. FATHER'S NAME <b>Jacob Frank Roessner</b>		14. MOTHER'S MAIDEN NAME <b>Vinona Thum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>C. Robert Shank, Catonsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of palate and Nasopharynx</b> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>20 months</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lobular Pneumonia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 21, 1960</b> to <b>March 2, 1961</b> , that (I) last saw the deceased alive on <b>March 2, 1961</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Young E. Chun</b>		22b. DATE <b>March 2, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>		22d. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

11-1-57

CERTIFICATE OF DEATH

2052

Residence

Age

Sex

Color

State of Birth

County

Married

Occupation

Education

Religion

Signature

Physician

Witness

Time

Date

Place of Death

RECEIVED  
FEB 1 1957  
FBI - NEW YORK

CHUV

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3653

03648

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>80 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Martin Manor Nursing Home</b>				d. STREET ADDRESS <b>144 E. Lincoln Ave.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SUSAN DELLA SHRODER</b>		First Middle Last		4. DATE OF DEATH <b>March 26 1961</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1873</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Shippensburg, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Edward Keefer</b>				14. MOTHER'S MAIDEN NAME <b>Frances Shillito</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Virginia Cook</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease with myocardial infarct</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO <b>Broncho Pneumonia</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs + 1 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 55</b> 19 to <b>26 Mar</b> 1961 that (I) (we) last saw the deceased alive on <b>25 Mar</b> 1961, and that death occurred at <b>2450</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>F. F. Lusby</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>27 Mar 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>				22d. ADDRESS <b>2301 Potomac</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/29, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Honkley</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



2053

Washington

Washington

to Paris

Washington

Washington and Paris

in the Lincoln Ave.

March 26

White

is

June 13, 1873

87

possible

Philadelphia, Pa.

Grand Hotel

Frances Shillito

no

none

Miss, Francis Cook

Washington, Maryland

to the Washington and Paris

Washington and Paris

Washington and Paris

Washington and Paris

Washington and Paris

Washington and Paris

Washington and Paris

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3654

## CERTIFICATE OF DEATH

Reg. Dist. No.

03649

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 2</u>				e. STREET ADDRESS <u>Route 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Catherine</u> Last <u>Sister</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1901</u>	9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>61</u>	IF UNDER 24 HRS. Hours <u>61</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Staunton Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Tisdale, (Bertie Jane)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Henry Sister</u> Address <u>Same as deceased</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c) <u>331X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Healed tuberculosis. Bronchiectasis of left lung.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 71</u> Month <u>19</u> Day <u>19</u> Year <u>1961</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>61</u> , and that death occurred at <u>10:35</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Alice N. Cunningham</u> M.D. <u>(Covering for Dr. Byrkit while on vacation)</u>							
PHYSICIAN'S NAME (Type) <u>Alice N. Cunningham M.D. &amp; Dr. Max Byrkit 28 W. Potomac St. Williamsport, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Nott</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Nott</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
3655 CERTIFICATE OF DEATH 03650												
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>GERTRUDE EVELYN SLUSHER</b>						4. DATE OF DEATH <b>March 25 19 61</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 15, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Sperryville, Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>												
13. FATHER'S NAME <b>Henry A. Brown</b>						14. MOTHER'S MAIDEN NAME <b>Elmira Woodard</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>220-18-1125</b>		17. INFORMANT <b>Mr. Harry E. Slusher Hagerstown, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO <b>Hypertensive Cerebrovascular Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1/6/53</b> , 19....., to <b>3/25/61</b> , 19....., that (I) (we) last saw the deceased alive on <b>3/25/61</b> , 19....., and that death occurred at.....M, from the causes and on the date stated above.												
22a. SIGNATURE <b>Searl Young</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/27/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>SEARL YOUNG</b>						22d. ADDRESS <b>148 W. Potomac Hagerstown Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/28/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Hagerstown Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Rouzer</b>						ADDRESS <b>Hagerstown, Md.</b>			25a. REC'D BY REGISTRAR <b>APR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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Washington

Washington

Washington

29 years

Washington County Hospital

W. W. Wilson

Birth

Birth

Birth

Birth

December 15, 1899

Female White

Rockville, Virginia

Rockville

Elizabeth W. ...

Henry A. ...

3-0-1-123 Mr. Henry A. ...

no

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Washington

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Washington, D.C.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3656

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03651

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Omer</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 5, 1895</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Smithsburg, d.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Luther Smith</b>		14. MOTHER'S MAIDEN NAME <b>Beadie Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. 1 222-10-3530</b>	
17. INFORMANT <b>Mrs. Nada B. Smith</b>		Address <b>Cavetown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> DUE TO <b>CEREBRAL HEMORRHAGE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b> DUE TO (b) <b>UNKNOWN</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>0</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1961</b> , to <b>March 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>MARCH 1, 1961</b> , and that death occurred at <b>2:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>S. R. Lowry</b>		22b. DATE <b>3-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ER LARIZADAL</b>		22d. ADDRESS <b>Smithsburg, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Smithsburg, Md.</b>	
25a. REC'D BY REGISTRAR <b>DATE MAR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u>		c. LENGTH OF STAY IN 1b <u>Most of life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R # 1</u>				d. STREET ADDRESS <u>R # 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Gertrude</u> Last <u>Snodderly</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cedar Lawn, Wash. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry C. Rummel</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Eavey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Walter C. Snodderly Sr. R # 1 Williamsport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ac. hypo cardiac infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/22/61</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>3/22/61</u> 19 <u>  </u> , and that death occurred <u>1:30 P</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Young</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>				22d. ADDRESS <u>101 E. Potomac St. Williamsport, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

Wm. A. Hoss

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3658

## CERTIFICATE OF DEATH

03653

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 Mos</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Conv Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>813 West Washington St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CORBIN</u> First <u>HOLLINGSWORTH</u> Middle <u>SNYDER</u> Last				4. DATE OF DEATH <u>March 23 1961</u> Month <u>19</u> Day <u>19</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 2 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Enna Mendenhall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>211-09-1926</u>		17. INFORMANT <u>Mrs Pearl Mullenix</u>		Address <u>876 Virginia Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fractured wrist (left.)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathroom.</u>					
20c. TIME OF INJURY Month, Day, Year <u>Mar 14, 1961</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) <u>Hagerstown Wash. Md</u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1959</u> to <u>Mar 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 22, 1961</u> , and that death occurred at <u>3:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David R. Brewer</u>				22b. DATE SIGNED <u>3/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>				22d. ADDRESS <u>Clear Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery near Clear Spring Wash Co Md.</u>		23d. LOCATION (City, town, or county) <u>  </u> (State) <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffin</u>				25a. REC'D BY REGISTRAR <u>MAR 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3659

## CERTIFICATE OF DEATH

03654

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>most of life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Washington</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>525 N. Locust Street</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>LILLIE VIOLET SNYDER</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>10</b> Year <b>1961</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 17, 1886</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Clearspring District, Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>George William Bloyer</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Charlotte Wishard</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Joseph C. Snyder Hagerstown, Maryland</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>general arteriosclerosis and</b> (a), stating the underlying cause last. (c) <b>arteriosclerotic heart disease</b>												INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. _____ p.m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>June 24, 1860</b> to <b>June 10, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>June 10, 1961</b> , and that death occurred at <b>6:30</b> M., from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <b>Edward W. Ditto III</b> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>3/11/61</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edward W. Ditto III, M. D.</b>						<b>22d. ADDRESS</b> <b>217 West Washington St.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>3/13/1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Paul's Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>St. Paul's</b> <span style="float: right;">(State) <b>Maryland</b></span>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Suter - Rouzer Funeral Home</b> <b>H. Franklin Rouzer</b>						<b>ADDRESS</b> <b>Hagerstown, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 14 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Charlotte's

Joseph C. Smith, Washington, D.C.

on



Washington, D.C. July 1, 1916

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>32 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1410 Oak Hill Avenue</b>					d. STREET ADDRESS <b>1410 Oak Hill Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Miller</b> Last <b>Snyder</b>					4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1961</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1888</b>		9. AGE (In years lost birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>vice-president</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>building supplies</b>		11. BIRTHPLACE (State or foreign country) <b>Boonsboro, Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>George E. Snyder</b>					14. MOTHER'S MAIDEN NAME <b>Fannie Miller</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW I 214-09-8881</b>		17. INFORMANT Address <b>Helen P. Snyder, Hagerstown, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the urinary bladder</b> 1880 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9 1959</b> to <b>March 17 1961</b> that (I) (we) last saw the deceased alive on <b>March 15 1961</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>B. B. Kneisley</b>					22b. DATE <b>3/18/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>					22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Waynesboro, Penna.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAR 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton L. Kinn</b>		

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND  
**CERTIFICATE OF DEATH**

3661

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03657

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>127 East Antietam St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL ANGLE SPICKLER</u>				4. DATE OF DEATH Month Day Year <u>March 24 1961 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1901</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed Broadfording Wash Co Md</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alvey Spickler</u>				14. MOTHER'S MAIDEN NAME <u>Elva Angle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-091-1061</u>			
17. INFORMANT <u>Mrs Norma V. Spickler</u>				Address <u>127 E. Antietam St Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Non hemolytic Streptococci bacteria</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Malnutrition self imposed arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>3 days</u> <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 21</u> 19 <u>61</u> , to <u>Mar 24</u> 19 <u>61</u> , that (I) <u>xx</u> last saw the deceased alive on <u>Mar 24</u> 19 <u>61</u> , and that death occurred at <u>7p</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis G. Graff</u> M.D.				22b. DATE SIGNED <u>3-25-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>				22d. ADDRESS <u>119 E. Antietam St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>			
25a. REC'D BY REGISTRAR <u>MAR 29 1961</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3662

## CERTIFICATE OF DEATH

03656

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home Virginia Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. James</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Aleatha Pearl Sperow</u>		4. DATE OF DEATH <u>March 15 1961</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1879</u>	9. AGE (In years last birthday) <u>81 yrs.</u>	IF UNDER 1 YEAR <u>5</u> Months <u>15</u> Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Aaron Cushwa Middlekauff</u>			14. MOTHER'S MAIDEN NAME <u>Laura Eakle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clarence Sperow</u> Address <u>St. James, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>cc. myocardial dysfunction in heart</u> DUE TO (b) <u>INTERVAL BETWEEN ONSET AND DEATH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/15/61</u> to <u>3/15/61</u> that (I) (we) last saw the deceased alive on <u>3/15/61</u> and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Young</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u>			
23d. LOCATION (City, town or county) <u>Bakersville, Md.</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u> ADDRESS <u>Williamsport, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 21 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

3883



Washington

Virginia

Washington

1871

1871

1871

John J. ...

Ala. ...

Ala. ...

Female ...

Female ...

Female ...

Female ...

Female ...

Female ...

John J. ...

John J. ...

John J. ...

*is prepared to ...*

*2/12 ...*

*John J. ...*

Washington, D.C. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

3663

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03658

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SMITHSBURG RURAL</b> <b>X</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>SMITHSBURG RT. #2</b>		1	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NRTTIE JULIA STEVENS</b>				4. DATE OF DEATH Month Day Year <b>MARCH 12 19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/27/1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM HENRY DENNIS</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA SNIVLEY STRITE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT Address <b>MR. LAUREN STEVENS BIG SPRING MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis, Severe</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b> <b>Recent</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i> EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3-13-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/15/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CHURCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norman Hagerstown, Md.</i> ADDRESS				24. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3664

## CERTIFICATE OF DEATH

Reg. Dist. No.

03659

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>20 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1108 Resumer ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jeffrey</u> Middle <u>Allen</u> Last <u>Stearns</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/61</u>	9. AGE (In years last birthday) <u>20 hrs.</u>	IF UNDER 1 YEAR Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min. <u>30</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Albert Stearns</u>				14. MOTHER'S MAIDEN NAME <u>Lou Ann Stearns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>H. D. Bowman James Albert Stearns</u> Address <u>1108 Resumer ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>61</u> , to <u>3/6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>61</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>3/8 H. Potomac St. Hagerstown, Md</u> DATE SIGNED <u>3/7/61</u>			
PHYSICIAN'S NAME (Type) <u>Dr. H. D. Bowman</u>				<u>318 North Potomac Street, Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>3/15/61</u>		<u>Wash. Co. Hosp. Lab.</u>		<u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Schaffer, Adm.</u>				24a. REC'D BY REGISTRAR <u>Hospital</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

2081254XVU

CERTIFICATE OF DEATH

1954

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		39		12/1/1914		MOBILE, ALABAMA		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
4/4/68		10:00 AM		ST. LOUIS, MISSOURI		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. SOCIAL SECURITY NUMBER		22. FINGERPRINTS		23. PHOTOGRAPH		24. OTHER	
ST. LOUIS		ST. LOUIS		MISSOURI		63101		123-45-6789		[ ]		[ ]		[ ]	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF MORTUARY		31. SIGNATURE OF BURIAL		32. SIGNATURE OF CREMATION	
[ ]		[ ]		[ ]		[ ]		[ ]		[ ]		[ ]		[ ]	

1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2665

03660

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Md State Hosp</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ima</b> Middle <b>Dwilla</b> Last <b>STOTLER</b>				4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14 1888</b>		9. AGE (In years last birthday) <b>72</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Stotler</b>				14. MOTHER'S MAIDEN NAME <b>Lutie Summers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daniel D. Stotler</b> Address <b>147 Bellview Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant melanoma of right ankle with wide spread metastasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1907 INTERVAL BETWEEN ONSET AND DEATH <b>5 years + 3 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 23 1960</b> to <b>March 31 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>March 31 1961</b> , and that death occurred at <b>6:05 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Young E. Chun</b>				22b. DATE SIGNED <b>March 31 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>				22d. ADDRESS <b>1500 Penna Ave Hagerstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				25a. REC'D BY REGISTRAR <b>APR 3 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

117-100-100 TWO-MINUTE TEST ON 11/1/11

1 **MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3666

03661

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Smithsburg, R.D. 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>May</b> Last <b>Trumpower</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 61</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 2, 1882</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Md. R.D.2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cyrus B. Bachtell</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Suter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Robert N. Bachtell Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Auricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>10 Yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr.</b> <b>1 Wk.</b> <b>10 Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-8</b> <b>1961</b> to <b>3-18</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>3-18</b> <b>1961</b> and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles F. Hess</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-19-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>				22d. ADDRESS <b>Smithsburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stouffers Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md. R.D.2</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Z. Grove</b>				ADDRESS <b>Waynesboro, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 22 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1966

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
BUREAU OF VITAL STATISTICS  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

NAME: \_\_\_\_\_  
AGE: \_\_\_\_\_  
SEX: \_\_\_\_\_  
RACE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
PLACE OF BIRTH: \_\_\_\_\_  
DATE OF DEATH: \_\_\_\_\_  
PLACE OF DEATH: \_\_\_\_\_  
CAUSE OF DEATH: \_\_\_\_\_  
MANNER OF DEATH: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_  
TITLE: \_\_\_\_\_  
DATE: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3667

CERTIFICATE OF DEATH

302

03662

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>ELLEN</b> Last <b>TURNER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 24 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Renner</b>		14. MOTHER'S MAIDEN NAME <b>May Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>— — — —</b>	
17. INFORMANT <b>James R. Turner</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>151X</b> DUE TO <b>Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>21 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/14</b> <b>1959</b> to <b>3/30</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> <b>1961</b> , and that death occurred at <b>P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>George Jennings</b>		22b. DATE <b>4/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Jennings</b>		22d. ADDRESS <b>Hagerstown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 3 '61</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Turner</b>	

I, the undersigned, Clerk of the County of \_\_\_\_\_ State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the \_\_\_\_\_  
 of \_\_\_\_\_  
 as the same appears from the records of said County.  
 Given under my hand and the seal of said County, this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 1907.  
 \_\_\_\_\_  
 Clerk of the County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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3668  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03663

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Orville</b> Last <b>Weller</b>		4. DATE OF DEATH Month <b>3</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7.25.1927</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vernon Weller</b>		14. MOTHER'S MAIDEN NAME <b>Iva Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Vernon Weller Rural 2 Hancock Md.</b>	
17. INFORMANT <b>Vernon Weller Rural 2 Hancock Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Embolism</b> DUE TO <b>Rheumatic Heart Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Had heart surgery 5 yrs. ago</b> (c) <b>Had heart surgery 5 yrs. ago</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1961</b> to <b>Mar 8, 1961</b> that (we) last saw the deceased alive on <b>Mar 8, 1961</b> , and that death occurred at <b>PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David R. Brewer</b>		22b. DATE SIGNED <b>3/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		22d. ADDRESS <b>Clear Spring Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3.11.61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Orchard Ridge Cemetery Rural Hancock Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Gurne</b>		25a. REC'D BY REGISTRAR <b>MAR 13 '61</b>	
ADDRESS <b>Hancock Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

STATEMENT OF DEATH  
CERTIFICATE OF DEATH

3358

County of ... State of ...

Name of Deceased ...

Age ...

Sex ...

Date of Death ...

Place of Death ...

Signature of Physician ...

Signature of Registrar ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Item 14 Film G284 4/10/61 jwk														
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md. b. COUNTY Wash.									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY in 1b 80 years									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 301 W. Wilson Blvd.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown									
3. NAME OF DECEASED (Type or print) First Harry Middle William Last Wellinger					4. DATE OF DEATH Month March Day 28, Year 19 61									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1880		9. AGE (In years last birthday) 80						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gang leader		10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.			12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Jacob Wellinger					14. MOTHER'S MAIDEN NAME Mary Baur									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO.					17. INFORMANT Address Karl Wellinger, Alexander, Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized and DUE TO Arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Prostatic hyperplasia - INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Schward W. Ditto			CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) burial			22b. DATE THEREOF 3-30-61		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown, Md.							
23. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son, Hagerstown, Md.					24a. REC'D BY REGISTRAR DATE APR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krause							





## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3670

03665

Item 23b, Film G264 4/12/61 JWK

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Greencastle</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>130 N. Carlisle St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Blanche</u> Last <u>White</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23 1865</u>
9. AGE (In years lost birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Greencastle, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Edward David Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Lucinda Reid</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Samuel Hunter</u> Address <u>915 Orchard Hill Road, Roanoke, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Bronchial Pneumonia</u> DUE TO (b) <u>Tenintion</u> DUE TO (c) <u>Arteriosclerosis - Gen.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>6 mo.</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mer 12, 1960</u> to <u>Mar. 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar. 30, 1961</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffma</u> M.D.		22b. DATE SIGNED <u>4-2-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffma</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 3, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Quinn</u> ADDRESS <u>Greencastle Pa</u>		25a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Lloyd Hoffma  
214 N. Potomac

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3671  
CERTIFICATE OF DEATH

03666

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R#1</u> c. LENGTH OF STAY IN 1b <u>20 Yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Day Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 1</u> d. STREET ADDRESS <u>Day Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY GENEVIEVE WILEY</u> First Middle Last		4. DATE OF DEATH <u>March 4 1961</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 1887</u> lost birthday) yrs.
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>Sanford Sease</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Fergusson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry W. Wiley</u> Address <u>Day Road Hagerstown Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO <u>Hypertension + Arteriosclerosis Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>vascular disease</u> (b) <u>vascular disease</u> (c) <u>vascular disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3 Mar 1961</u> to <u>4 Mar 1961</u> , that (I) (we) lost saw the deceased alive on <u>3 Mar 1961</u> , and that death occurred at <u>130 M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>F. F. Lusby</u> M.D.		22b. DATE SIGNED <u>4 Mar 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>		22d. ADDRESS <u>230N Potomac St Hagerstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 7 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		25c. REGISTRAR'S SIGNATURE	

CONFIDENTIAL - DEATH

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CONFIDENTIAL - DEATH

CONFIDENTIAL - DEATH

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3672

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03667

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>11 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Jackson Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Braddon Wilson</b>		4. DATE OF DEATH Month Day Year <b>March 1 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. FATHER'S NAME <b>Henry Braddon</b>		14. MOTHER'S MAIDEN NAME <b>Grute</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles R. Wilson</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestion heart failure &amp; pneumonia</b> 450.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/27/61</b> 19 to <b>3/1/61</b> 19, that (I) (we) last saw the deceased alive on <b>2/28/61</b> 19, and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks, M.D.</b>		22b. DATE SIGNED <b>3/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>136 N. Potomac St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 6 '61</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	

CERTIFICATE OF DEATH

3533

Place of Birth

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

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3673

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03668

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>ONE WEEK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. CO. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>VERNON</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 9 - 1875</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>7</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER - GENERAL BUILDING</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NR. MIDDLETOWN</b>			
11. BIRTHPLACE (State or foreign country) <b>FRED. CO. M.D.U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JONAS S. YOUNG</b>				14. MOTHER'S MAIDEN NAME <b>ANNA SOPHIA SIGLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-07-7120</b>			
17. INFORMANT <b>ROSCOE YOUNG</b>				Address <b>4234 CARWELL AVE BALTIMORE 6, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 42010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10-14 yrs.</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> 19 <b>55</b> to <b>3/17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Kenneth C. Henson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Kenneth C. Henson</b>				22d. ADDRESS <b>Middletown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 19, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>				25a. REC'D BY REGISTRAR <b>BOOKSBORO MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
				DATE <b>MAR 21 '61</b>			

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1930

CERTIFICATE OF DEATH

115064

WASHINGTON, D.C. DECEMBER 1, 1930

NAME: JOHN W. BROWN

AGE: 45 YEARS

SEX: MALE

RACE: WHITE

DATE OF DEATH: DECEMBER 1, 1930

PLACE OF DEATH: HOME, 1234 12th St. N.W., Washington, D.C.

CAUSE OF DEATH: Myocardial Infarction

DIAGNOSIS: Myocardial Infarction

DATE OF BIRTH: JANUARY 1, 1885

PLACE OF BIRTH: BOSTON, MASS.

SIGNATURE: J. W. BROWN